LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **SB 110** SLS 23RS 352
Bill Text Version: **REENGROSSED**
Opp. Chamb. Action: **w/ HSE COMM AMD**
Proposed Amd.:
Sub. Bill For.:

Date: May 22, 2023 6:19 AM
Author: TALBOT
Dept./Agy.: Insurance and Group Benefits
Subject: Cancer Patient's Right to Prompt Coverage Act
Analyst: Patrice Thomas

INSURANCE POLICIES RE1 INCREASE SG EX See Note

Provides for patient's right to prompt coverage. (8/1/23)

Proposed law creates the "Cancer Patient's Right to Prompt Coverage Act". For any service related to the diagnosis or treatment of cancer, proposed law requires health insurance plans to communicate their decision on the prior authorization requests within 48 hours of receipt of the request for expedited review; 5 days when an expedited review is not requested; and 14 days if additional information was requested and received. Proposed law prohibits denying a prior authorization or payment of claims for diagnosis or treatment related to that cancer is recommended by national clinical practice guidelines or consensus statements. Proposed law prohibits denying coverage of positron emission tomography (PET) or other recommended imaging. Proposed law requires outpatient services for the treatment of cancer to be covered. Proposed law is subject to annual deductibles, coinsurance, and copayments. Proposed law effective January 1, 2024 (new health coverage plans) and January 1, 2025 (existing health coverage plans).

EXPENDITURES	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**2027-28**	**5 -YEAR TOTAL**
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

REVENUES	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**2027-28**	**5 -YEAR TOTAL**
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

EXPENDITURE EXPLANATION

Proposed law will increase Self-Generated Revenue expenditures within the Office of Group Benefits (OGB) beginning in FY 24. Furthermore, proposed law will increase claims expenditures for the health insurance industry by an estimated $5.2 M to $8.7 M and premiums by an estimated $6.1 M - $10.3 M in FY 24 (see Expenditure Explanation on Page 2).

Office of Group Benefits Impact (Self-Generated Revenue Impact)

Proposed law increases expenditures within the Office of Group Benefits (OGB). The proposed law requires OGB to cover benefits under the "Cancer Patient's Right to Prompt Coverage Act", which includes expedited prior authorization for PET scans and other imaging services, radiation oncology, and genetic testing for members with a cancer diagnosis. Based upon the assumptions listed below, the expenditures to cover this benefit range are as follows:

	FY 23-24	FY 24-25	FY 25-26	FY 26-27	FY 27-28	Total
Low	$1,585,728	$3,298,315	$3,430,247	$3,567,457	$3,710,155	$15,591,902
High	$2,543,343	$5,290,153	$5,501,759	$5,721,829	$5,950,702	$25,007,786

*FY 23-24 represent 11 months of estimated claims expenditures

Unless OGB Fund Balance is utilized, SGF appropriation will be required to cover the state portion of the increase in premium costs, which is approximately 41%. As of February 2023, OGB reports a $434 M fund balance.

The expenditure estimate is based upon the following assumptions: (1) As of 5/01/2023, the current OGB member population in the five self-funded health plans is 165,015 (excluding 43,515 Medicare primary members, total members of 208,530). Membership will remain constant. (2) The coverage will become effective on 1/01/2024. (3) No change in OGB self-funded health plan membership in future fiscal years from current levels. (4) The per member per month (PMPM) cost estimate provided by BCBSLA range from $1.54 pmpm (low) or $2.47 pmpm (high). (5) In future fiscal years, a medical inflation factor of 4%.

See EXPENDITURE EXPLANATION on Page 2

REVENUE EXPLANATION

The Office of Group Benefits (OGB) does not anticipate the proposed law to require premium increases, therefore there is no impact on self-generated revenues collected from premiums. OGB has indicated the estimated costs associated the "Cancer Patient's Right to Prompt Coverage Act" may be absorbed by the existing fund balance reserve. However, to the extent other legislative instruments that are enacted expand covered medical and pharmacy benefits, the cumulative impact may be material and require OGB to increase premiums to maintain an actuarially sound fund balance of $250 M.

Senate Dual Referral Rules

[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S & H}

[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S & H}

House

[x] 6.8(F)(1) >= $100,000 SGF Fiscal Cost {H & S}

[ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

Evan Brasseaux

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CONTINUED EXPLANATION from page one:

EXPENDITURE EXPLANATION Continued from Page 1

Based on the aforementioned methodology on page one, the assumption that coverage will only be in place for 6 months in FY 24 due to the January 1, 2024 effective date, the per member per month (PMPM) cost estimates range from a low of $1.54 pmpm to a high of $2.47 pmpm, and a medical inflation (MI) factor of 4% compounding annually, below are expenditure calculations utilized to project the cost within OGB utilizing the assumptions listed on page one.

Expenditure Calculations = membership population x PMPM cost x 12 months
Base Cost (Low) = $3,049,477 = 165,015 x $1.54 x 12 months
Base Cost (High) = $4,891,045 = 165,015 x $2.47 x 12 months

FY 24 (Low) = $3,171,456 = $3,049,477 x 4% MI ($1,308,159 SGF)
FY 24 (High) = $5,086,686 = $4,891,045 x 4% MI ($2,098,151 SGF)

FY 25 (Low) = $3,298,315 = $3,171,456 x 4% MI ($1,360,486 SGF)
FY 25 (High) = $5,290,153 = $5,086,686 x 4% MI ($2,182,077 SGF)

FY 26 (Low) = $3,430,247 = $3,298,315 x 4% MI ($1,414,905 SGF)
FY 26 (High) = $5,501,759 = $5,290,153 x 4% MI ($2,269,360 SGF)

FY 27 (Low) = $3,567,457 = $3,430,247 x 4% MI ($1,471,501 SGF)
FY 27 (High) = $5,721,829 = $5,501,759 x 4% MI ($2,360,135 SGF)

FY 28 (Low) = $3,710,155 = $3,567,457 x 4% MI ($1,530,361 SGF)
FY 28 (High) = $5,950,702 = $5,721,829 x 4% MI ($2,454,540 SGF)

Total (Low)* = $17,177,631 ($ 7,085,412 SGF)
Total (High)* = $27,551,129 ($11,364,263 SGF)
*The Total does not include the Base Costs.

Insurance Exchanges Impact (State General Fund Impact)
There is no anticipated impact on the insurance exchanges as a result of this measure.

PRIVATE INSURANCE IMPACT
Pursuant to R.S. 24:603.1, the information below is the projected private insurance impact of proposed law. Based upon an actuarial analysis prepared by LDI, the proposed law is anticipated to increase expenditures associated with claims by $5.2 M - $8.7 M and premium increases by $6.1 M - $10.3 M for private insurers and the insured in FY 24 (6 months) with a phase-up costs of an estimated $13 M - $21.9 M claims and $15.3 M - $25.8 M premiums by FY 28. LDI bases this analysis on the following assumptions: the calculations are on a fiscal year basis; the exchange population is approximately 650,000 and the insured population is assumed to be stationary; medical cost inflation is 8% in FY 25 and 5% in subsequent fiscal years; the premium loss ratio is 85%; and **the estimated cost is between $1.34 PMPM and $2.25 PMPM over the entire insured population**. Based upon the aforementioned assumptions, the estimated annual cost increases for insurance providers associated with claims are as follows:

Aggregate Cost Determination
(exchange population x PMPM cost x 12 months x MI)
FY 24 (Low) - 650,000 x $1.34 x 12 months = $10,452,000*
FY 24 (High) - 650,000 x $2.25 x 12 months = $17,550,000*

FY 25 (Low) - $10,452,000 x 8% MI = $11,288,160
FY 25 (High) - $17,550,000 x 8% MI = $18,954,000

FY 26 (Low) - $11,288,160 x 5% MI = $11,852,568
FY 26 (High) - $18,954,000 x 5% MI = $19,901,700

FY 27 (Low) - $11,852,568 x 5% MI = $12,445,196
FY 27 (High) - $19,901,700 x 5% MI = $20,896,785

FY 28 (Low) - $12,445,196 x 5% MI = $13,067,456
FY 28 (High) - $20,896,785 x 5% MI = $21,941,624

Aggregate Extra Premium Determination
(PMPM cost x 12 months)/medical loss ratio x MI
FY 24 (Low) - ($1.34 x 12 months)/85% = $18.92*
FY 24 (High) - ($2.25 x 12 months)/85% = $31.76*

FY 25 (Low) - $18.92 x 8% MI = $20.43
FY 25 (High) - $31.76 x 8% MI = $34.31

FY 26 (Low) - $20.43 x 5% MI = $21.45
FY 26 (High) - $34.31 x 5% MI = $36.03

FY 27 (Low) - $21.45 x 5% MI = $22.52
FY 27 (High) - $36.03 x 5% MI = $37.83

FY 28 (Low) - $22.52 x 5% MI = $23.65
FY 28 (High) - $37.83 x 5% MI = $39.72

*FY 23-24 calculations must be adjusted to represent 6 months of estimated claims expenditures and premium determination to reflect an effective date of January 1, 2024.

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